Menopause Symptoms and Attitudes of African American Women: Closing the Knowledge Gap and Expanding Opportunities for Counseling

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Menopause, a normal midlife transition for women, remains poorly understood, especially for minority women. A total of 226 African American midlife women completed the Menopause Symptoms List (J. M. Perz, 1997); Menopause Attitude Scale (C. Bowles, 1986); Attitudes Toward Menopause checklist (B. L. Neugarten, V. Wood, R. J. Kraines, & B. Loomes, 1963); and instruments to elicit information about health status, stressful life events, social support, and demographics. The results reveal strengths as well as areas of concern for African American women in responding to normative midlife changes. Implications for counselors are explored.

Menopause is a universal female midlife transition that remains poorly understood (Huffman & Myers, 1999). Most of the research concerning women's experiences of menopause has focused on biological and psychological changes, or "symptoms" according to the medical model (Neugarten & Kraines, 1965). The types, incidence, and severity of symptoms have been shown to vary among women both within the same culture and between different cultures (Kaufert & Syrotuik, 1981).

Although the available literature provides clear support for the relationship between attitudes and perceptions, behaviors, and experiences, studies of women's attitudes toward menopause have primarily involved Caucasian, middle- and upper-class, well-educated women (Mansfield & Voda, 1993; Rousseau & McCool, 1997; Theisen, Mansfield, Seery, & Voda, 1995). Only a few recent studies have attempted to include minority women, but they have had only marginal success recruiting participants (Kaufert & Lock, 1997). One exception to the problem of sampling minority populations is the ongoing Study of Women Across the Nation (DeAngelis, 1997). Launched in 1994 and continuing until 1999, this study was designed to investigate the variations of menopausal experiences among ethnic groups in the United States. Preliminary findings suggest that attitudes toward menopause vary among different ethnic groups, which supports conclusions of other investigators that results from one population of women cannot be generalized to another population (Tang, 1994; Theisen et al., 1995). Because of the lack of empirical evidence on the menopausal experiences of minority women, professional interventions are based on research on the symptoms experienced by Caucasian women, as well as on the attitudes of these women toward their menopausal experiences.

Symptoms attributed to menopause affect every body system, making it difficult to differentiate coincidental pathological changes or other age-related changes from those purely related to menopause (Neugarten & Kraines, 1965). More than 100 menopausal symptoms have been identified (Ditkoff, Crary, Cristo, & Lobo, 1991; Perz, 1997), with some of the most common ones including hot flashes, night sweats, vaginal dryness, reduced libido, sleep disturbance, irritability, depression, anxiety, tension, palpitations, headaches, poor concentration, forgetfulness, and fatigue (Ballinger, 1990; Morse et al., 1994). Several longitudinal studies of nonclinical populations indicate that hot flashes and night sweats are the only symptoms that women universally and consistently report (Kaufert & Syrotuik, 1981). Approximately 50% to 85% of women experience hot flashes with varying degrees of frequency and intensity (Bowles, 1990).

Consistently, women who are seeing physicians for menopausal and related health and mental health concerns have

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reported more psychological and physiological problems than menopausal women from the general population who are not seeing physicians (Dennerstein, Smith, & Morse, 1994; Morse et al., 1994). In nonclinical studies, only 10% of women report significant physical symptoms (Ford, 1996; Oldenhave & Netelenbos, 1994). Such findings support Ballinger's (1990) suggestion that if symptom reporting from clinic populations is considered representative of the general population of menopausal women, the presence of symptoms will be overestimated.

Neugarten, who pioneered general population studies of symptomatology, was also instrumental in turning the attention of researchers to the study of attitudes toward menopause (Kaufert & Syrotuik, 1981). Numerous studies of attitudes reveal that they are influenced by sexist and ageist stereotypes (Leiblum & Swartzman, 1986). Positive attitudes toward menopause are associated with positive experiences of menopause, whereas negative attitudes are associated with both negative symptoms and negative experiences (Dennerstein et al., 1994).

Little baseline information exists from which to understand what constitutes normal menopause experiences among African American women. The research that is available suggests that variations in menopausal symptomatology and disease processes exist, both interethnically and intraethnically. If counselors and health care providers are going to help this population of women understand and cope with menopause, the normal parameters of menopausal change among African American women must be identified (Rousseau & McCool, 1997). Thus, the present study was undertaken to determine the attitudes toward menopause and menopausal symptoms of midlife African American women.

Method

The population of interest for this study included African American women between the ages of 35 and 55, traditionally a population difficult to access. A convenience sample was recruited using a snowball sampling technique (Jones, 1997) in which identified participants suggested other women whom they believed would also take part in the study. Recruitment resources included churches, professional and social organizations, community group meetings, and medical practices. Although participants were from 21 different states across the United States, most were recruited from the southeastern United States. Of the 400 distributed questionnaires, 226 were valid for a response rate of 56.5%.

As shown in Table 1, the participants were a heterogeneous sample of African American women in terms of age, marital status, education, and income. Slightly more than one third (35.4%) were college graduates, most (81%) were employed outside the home, and more than half (56.2%) had incomes above $30,000 per year. Thus, they were comparable in many ways to the existing samples of Caucasian women surveyed in earlier studies. However, an attempt was made to obtain a representative sample of African American women on the basis of socioeconomic status, and as a consequence more than one fourth (26.1%) of the participants reported incomes of less than $20,000 per year. Thirty-three percent of the participants had had a hysterectomy, with the average age when they had the hysterectomy being 39 years.

TABLE 1

Demographic Variables of Age, Marital Status, Geographic Location, Level of Education, Employment, and Level of Household Income

Demographic Variable	*n*	%[a]
Age		
35–39	44	19.50
40–44	38	16.80
45–49	75	33.10
50–55	58	25.70
Marital status		
Single	53	23.50
Married	103	45.60
Divorced	57	25.20
Widowed	13	5.70
Geographic location		
Rural	26	11.50
Small town	30	13.30
Small city	26	11.50
Moderate-size city	82	36.30
Large city	47	20.80
Education		
Less than high school	17	7.50
High school or GED	52	23.00
Some college	75	33.20
College graduate	50	22.10
Postgraduate	30	13.30
Employed outside the home	184	81.00
Household income		
$10,000 or less	27	11.90
$11,000–$20,000	32	14.20
$21,000–$30,000	37	16.40
$31,000–$40,000	29	12.80
$41,000–$50,000	33	14.60
$50,000 or more	65	28.80

Note. GED = general equivalency diploma.
[a]Percentages do not always equal 100 due to missing data.

Instrumentation

Participants completed five instruments: a demographic questionnaire that included an assessment of menopause status; a measure of life circumstances that included health status, stressful life events, and social support; the Menopause Symptoms List (MSL; Perz, 1997); the Menopause Attitude Scale (MAS; Bowles, 1986); and the Attitudes Toward Menopause checklist (ATM; Neugarten, Wood, Kraines, & Loomis, 1963). None of these instruments have been normed on minority women, reflecting the paucity of information on menopause in this population. Thus, to ensure the relevance of the instruments for this study, a convenience sample of 20 African American women were recruited and

asked to complete the instruments and provide feedback on their relevance and appropriateness as well as on the individual items that constituted the scales.

Menopause status. Menopause status was determined by the following: (a) Women who indicated that they had regular menstrual periods in the last 3 months were classified as premenopausal, (b) women who indicated their periods had become irregular but that they had had a period in the last 12 months were classified as perimenopausal, and (c) women who indicated they had not had a period in the last 12 months or longer were classified as postmenopausal. Women who indicated they had had a hysterectomy were classified as surgically menopausal.

Life circumstances. Health status, stressful life events, and social support have been identified in menopause research as factors influencing how women experience menopause (Dennerstein et al., 1994; Gannon & Ekstrom, 1993; Groeneveld et al., 1993; Jackson, 1990; Theisen et al., 1995). Subjective measures of health status were obtained by asking the following: if participants perceived their health to be poor, fair, good, or excellent; if they had been treated by a doctor for any of four chronic medical conditions (high blood pressure, diabetes, heart disease, and cancer) prevalent among African Americans (U.S. Department of Health and Human Services, 1986); and if they had in the last 6 months experienced any of eight areas of stress (husband, children, parents, work, housing, money, personal health, and illness or death of a loved one). To assess social support, women were asked to rate how difficult or how easy it was for them to talk to others about menopause and to indicate how many friends and family members they could talk to in a comfortable manner about menopause.

The MSL. The MSL was developed by Perz (1997) to measure the frequency of 25 symptoms often associated with menopause. Three factors underlying responses were labeled psychological, vaso-somatic, and general somatic symptoms. Test–retest reliability coefficients for a community sample of 40 women ages 45 to 55 were reported as .79, .72, and .92, respectively, for the three factors and .83 for the total set of items. The time interval between testing was not reported. Convergent validity was determined based on high correlations between scores on the MSL and the Climacteric Symptom Rating Scale (Greene, 1976).

The MAS. The MAS, a semantic differential scale (Osgood, Suci, & Tannenbaum, 1957), provides an overall positive or negative mean score concerning attitudes toward menopause (Bowles, 1986). It is designed to measure one factor, the evaluative dimension of the attitude construct. The Cronbach alpha estimate of internal consistency reliability of the MAS was .96, and 2-week test–retest reliability was .87. Bowles (1986) reported the mean interitem correlation as .59, with a minimum correlation of .40 and a maximum of .84.

ATM. Neugarten et al. (1963) developed the ATM to assess 35 specific attitudes toward menopause. Responses are made in terms of what one believes women in general think about menopause. Content validity for the ATM was established based on extensive face-to-face exploratory interviews with middle-aged women and from literature that was available at the time the instrument was developed. Through factor analysis, seven underlying factors were identified that accounted for 85% of the variance in scores: Negative Affect, Postmenopausal Recovery, Extent of Continuity, Control of Symptoms, Psychological Losses, Unpredictability, and Sexuality. Bowles (1986) reported an alpha coefficient of .80 for the ATM total score; the alpha coefficient for the current study was .64.

Several of the African American women who participated in the pilot study were asked to evaluate the positive or negative nature of each ATM item. Negative items were reverse scored so that higher scores indicated positive attitudes. Based on additional feedback, minor revisions in wording were made and "dated" items from the ATM were removed.

Data Analysis

Frequencies were computed for all items and scales as well as alpha coefficients for the scales. Because both the ATM and MAS scores represent attitudes, these were combined into one variable (attitude) by standardizing each respondent's score (yielding a *z* score) and obtaining an average of the two variables. The newly created "attitude" variable was used in the subsequent correlation, regression, and analysis of covariance analyses. Zero-order correlations were conducted among the scale scores and demographic variables, followed by regression analyses using simultaneous entry of predictors. The statistically significant predictor variables were used as covariates in the univariate analyses of covariance (ANCOVA) on the attitude and MSL variables.

Results

Response Frequencies for Measures of Life Circumstances, Stress, and Social Support

Almost three fourths (72.6%) of participants rated their health as *excellent* (14.2%) or *good* (58.4%), 23% considered it to be *fair,* and 3.5% considered it *poor.* Relative to high blood pressure, heart disease, diabetes, and cancer, 54.9% reported no chronic disease, 32.7% reported having one of the four diseases, 8.9% reported having two of the diseases, and 3.1% reported having three. Considering the eight possible areas of life stressors, 3.5% noted no stress in these areas, 34.5% indicated minor stress, and 61.9% indicated major stress in at least one of the areas. (In this and the following paragraphs, the percentages may not equal 100 due to missing data.)

Concerning social support, 39% of the participants indicated they found it very easy to talk to others about menopause, 48.2% found it easy, 9.7% found it difficult, and 2.7% found it very difficult. Respondents varied in the num-

ber of family and friends they had with whom they could talk comfortably about menopause: 5.3% reported having more than 15 persons, 9.3% indicated they had between 10 and 14 persons, 46.9% indicated they had 5 to 9 persons, 30.3% noted they had 1 to 4 persons, and 4.4% indicated they had no one with whom they could talk comfortably about menopause.

Two additional questions were asked to determine whether participants actually had talked openly to friends or family members about menopause and how easy or difficult it was for them to talk to their doctors about menopause. Of the four menopausal status groups, premenopausal women answered all of the questions related to social support the most positively, whereas postmenopausal women answered all questions most negatively, with one exception. Postmenopausal women indicated they had the highest number of persons with whom they could talk comfortably about menopause. An interesting contradiction was that, in actuality, they were the least likely of the groups to have talked to anyone about menopause during the time of pre- and perimenopause. It was not possible to determine from the data whether the size of social support systems had changed during their menopausal experiences.

Perceptions of Menopause

Three questions were asked to determine how the participants perceived menopause, with instructions to check the appropriate response option rather than provide open-ended comments. Fewer than 10% considered menopause a medical condition, 38% considered it a natural midlife transition that was dealt with best by taking hormone replacement, and 44% believed menopause was a natural midlife transition that was dealt with best by natural means. Women in the surgical menopause group were more likely than any other menopause status group to view menopause as a medical condition. Fifty-three percent indicated their greatest concern related to what to expect during menopause, such as when it would occur, fear of hot flashes, irritability, depression, and loss of sexual desire and enjoyment. A small number (6.5%) reported being most concerned about hormone replacement therapy, whereas 13.8% indicated they had no worries or concerns about menopause, some noting they were too young to have even thought about it. In response to the third question, which asked what they perceived the best thing about menopause to be, most indicated that the best thing about menopause was the end of menstrual periods.

Table 2 shows the total percentage scores of agreement with each of the 22 statements about menopause on the ATM rank ordered by frequency of response. Almost all (96%) of respondents believed that women should see a doctor at the time of menopause. Eighty-one percent considered menopause to be one of the biggest changes in a woman's life, 70% considered it an unpleasant experience, 60% believed that women naturally dread menopause, 46% believed women think of menopause as the beginning of the end, and 49% percent believed that women worry about losing their minds during menopause. On the positive side, about two thirds of participants believed that a woman is freer to do things for herself after menopause; that after menopause women feel calmer, happier, and freer to do things for themselves; and that women are generally calmer and happier after the change of life. Furthermore, 61% believed that after menopause women have a broader outlook on life. The lowest percentage of agreement (about 25%) was for the negatively worded items "Women often use the change of life as an excuse for getting attention" and "After the change of life, women do not consider themselves to be 'real women.'"

TABLE 2

Percentage of Participants Marking "Agree" or "Strongly Agree" on the Attitudes Toward Menopause Checklist

Statement	% Agreement
A woman should see a doctor at the menopause.	95.96
Menopause is one of the biggest changes that happens in a woman's life.	80.63
A woman is concerned about how her husband will feel about her after menopause.	70.78
Menopause is an unpleasant experience.	69.96
After the change of life, a woman feels freer to do things for herself.	67.44
Women generally feel better after the menopause.	64.90
Women are generally calmer and happier after the change of life.	64.15
A woman has a broader outlook on life after the change.	61.10
Menopause is a disturbing thing that women naturally dread.	60.00
Women should expect some trouble during menopause.	58.48
A woman's body may change in menopause, but otherwise, she doesn't change much.	58.45
It is no wonder women feel "down in the dumps" at the time of menopause.	57.34
Life is more interesting for a woman after menopause.	55.56
Changes inside the body that women cannot control cause all the trouble at menopause.	54.80
A woman gets more confidence in herself after the change of life.	51.85
Going through menopause really does not change a woman in any important way.	50.23
Women worry about losing their minds during the menopause.	48.64
Women think of menopause as the beginning of the end.	46.19
The only difference between a woman who has been through menopause and one who has not is that one menstruates and the other doesn't.	45.41
In truth, just about every woman is depressed about the change of life.	36.81
Women often use the change of life as an excuse for getting attention.	27.15
After the change of life, women do not consider themselves "real women."	25.24

Menopausal Symptoms

The five most frequently occurring symptoms for this population of women were weight gain, irritability, sleeplessness, depressed feelings, and headaches. An analysis of individual symptoms by menopause status groups suggests that with larger perimenopausal and postmenopausal status groups, hot flashes and night sweats were higher on the list.

Zero-Order Correlations

A series of zero-order correlations were computed among scores on "attitude" and several demographic variables. Income was positively correlated with both education ($r = .57$, $p < .01$) and health ($r = .31$, $p < .01$). Attitude was positively correlated with age ($r = .32$, $p < .01$). The total score on the MSL was negatively correlated with attitude ($r = -.16$, $p < .05$), income ($r = -.23$, $p < .05$), education ($r = -.27$, $p < .05$), health ($r = -.37$, $p < .05$), and stress ($r = -.392$, $p < .05$). All effect sizes were small. No relationship was found between total scores on the MSL and age ($r = .05$).

Regression Analysis

A stepwise regression analysis was conducted to determine the amount of variance in the scores on the attitude scales that was accounted for by eight variables: income, education, health, stress, social support, menopause status, age, and frequency of symptoms. Only two variables—age and frequency of symptoms—accounted for portions of the variance that were significant at the .05 level (10% and 4%, respectively). The same variables were regressed onto the MSL scores. Education, health, and stress accounted for portions of variance that were significant at the .05 level (5%, 5%, and 13%, respectively).

ANCOVA

Using the results from the regression analyses, the significant contributors to the partitioned variance were used as covariates in two separate ANCOVAs, the results of which are reported in Table 3. Main effects were found for both models, and two different post hoc procedures were used to further examine the findings. First, the conservative Bonferonni correction was applied, followed by the more liberal Student Newman-Keuls procedure.

The results of the ANCOVAs on the newly created attitude variable, using age and frequency of menopausal symptoms as covariates, indicated the full model was significant ($F = 6.9$, $p < .01$, $\eta^2 = .14$) but indicated a small effect size. Further testing using both a Bonferroni correction and Student Newman-Keuls resulted in no differences among menopausal groups on attitude. There were significant, yet small, effect sizes on the main effects of age ($F = 20.320$, $p < .01$, $\eta^2 = .09$) and frequency of symptoms ($F = 7.152$, $p < .01$, $\eta^2 = .03$).

Similarly, there was a significant result for the full model on MSL scores using education, health, and stress as covariates ($F = 17.18$, $p < .01$, $\eta^2 = .32$). The results of the post hoc tests using a Bonferroni adjustment indicated no significant differences among the menopausal groups. When the stringency of the Bonferroni test was lifted and a Student Newman-Keuls was used, significant differences were found between premenopausal women and those who had hysterectomies ($p < .05$) and between premenopausal women and perimenopausal women ($p < .05$). All main effects were significant but yielded small effect sizes: (a) health ($F = 16.9$, $p < .01$, $\eta^2 = .07$), (b) education ($F = 10.3$, $p < .01$, $\eta^2 = .05$), and (c) stress ($F = 14.8$, $p < .01$, $\eta^2 = .15$).

TABLE 3

Means, Standard Deviations, *F*, and η^2 for the Menopause Symptoms List (MSL) and Attitudes Scales by Menopause Status

Variable	*n*	*M*	*SD*	*F*	η^2
Attitude scales (*df* = 5, 206)[a]					
Premenopause	77	−0.16	1.8		.14
Perimenopause	44	−0.17	1.7		.09
Postmenopause	31	−0.17	1.5		.26
Surgical menopause	60	0.62	1.6		.01
Total	212	−0.03	1.7	6.9*	.14
MSL (*df* = 6, 216)					
Premenopause	78	1.3	0.62		
Perimenopause	45	1.7	0.76		
Postmenopause	35	1.6	0.77		
Surgical menopause	65	1.6	0.83		
Total	223	1.5	0.75	17.2*	.32

Note. $N = 226$.

[a]Average standardized score of the Menopause Attitude Scale and the Attitudes Toward Menopause checklist. Scaled 0 to 5, with 0 representing the absence of symptoms and 5 representing having symptoms almost all of the time.

*$p < .01$.

Discussion

The paucity of research on midlife African American women, including their menopausal experiences, prompted the collection and analysis of descriptive data for the present study. Midlife African American women (N = 226) completed a demographic form and measures of health status, stressful events, and social support, as well as measures of attitudes toward menopause and a checklist of menopausal symptoms. The majority of women reported being in good or excellent health, almost two thirds reported experiencing major life stressors, and most reported having multiple sources of social support. Both positive and negative attitudes toward menopause were checked with considerable frequency (i.e., two thirds or more of respondents), with 4 of 5 women indicating menopause is one of the biggest changes that happen in a woman's life. A series of zero-order correlations revealed low correlations and small effect sizes between attitudes toward menopause and menopausal symptoms and several demographic variables. Regression analyses revealed only small portions of variance in menopause attitudes or symptoms were accounted for by any of the predictor variables. ANCOVAs revealed small but significant effects for age and frequency of symptoms with menopause attitudes and for health, education, and stress with menopausal symptoms. These results should be interpreted with caution due to the small effect sizes. In an attempt to keep the questionnaires as short as possible, longer and more extensive instruments were avoided. In doing so, variability may have been sacrificed and possible true score differences obscured.

Previous studies have revealed that African American women of lower socioeconomic status experience the brunt of chronic stressful life events with less social support (Perlmutter & Bart, 1982); however, those studies have not targeted midlife women. It is interesting to note that the current sample, although primarily of higher socioeconomic status, also expressed a high level of stress. Thus, higher education and higher income did not insulate these women from high levels of stress in one or more of the areas of family relationships, work, finances, and personal health. Even African American women who are well educated and who enjoy a certain amount of prosperity cannot escape concerns of their extended families, the disproportionately fewer number of African American men in their communities, the duality of their African and American identities, as well as a variety of personal problems. However, the majority of women in the study reported having a network of friends and family members who provide social support and help mediate the effects of stressful life circumstances. Respondents characterized their relationships as comfortable and open to discussion of personal issues such as menopause.

If there is a taboo related to speaking about menopause in the African American culture, it did not appear to affect this population of women. Relatively few found it difficult to speak about menopause. It may be that this taboo has not only weakened in the larger U.S. culture (Mansfield & Voda, 1993) but also in the African American community. There was, however, wide variation in the number of support persons women said they had. This inequity in social support may contribute to differences in attitudes and experiences related to menopause. Theisen et al. (1995) and others have reported that women who have a social support network with whom they can speak about menopause report more positive attitudes toward menopause than do other women. Others have reported that positive attitudes toward menopause are related to positive experiences of menopause (Bowles, 1986).

Hot flashes and night sweats, the only two symptoms that have been universally identified with menopause (Kaufert & Syrotuik, 1981), were not among the top 10 symptoms reported by the African American women in this study. However, this finding appears to be due to the large number of premenopausal women in this sample. When only the perimenopausal women were considered, these two symptoms were among the most frequently reported. These findings are consistent with results from studies of Caucasian women whose menopausal symptomatology is reported to peak in perimenopause (Kaufert & Syrotuik, 1981; Oldenhave & Netelenbos, 1994). It was interesting to note that the level of symptoms did not return to the premenopausal level for women in postmenopause or surgical menopause. Research with Caucasian women suggests that the pattern of menopausal symptomatology generally demonstrates a marked lessening of symptoms within 2 to 5 years of the last menstrual period (Oldenhave & Netelenbos, 1994).

This pattern is not seen in the postmenopause group in this study and raises the question of whether African American women continue for a longer period of time to experience menopausal symptomatology. Hot flashes, which postmenopausal women report as continuing to occur at a rate significantly greater than among premenopausal women, are of importance because this menopausal symptom is recognized to be potentially disruptive to normal daily life and is the primary reason for women seeking medical attention during menopause. It is also noteworthy that the average age for hysterectomy was 39 years, compared with an average age of 46 for Caucasian women. It has been suggested that lack of knowledge of normal menopausal changes among African American women has limited their ability to self-advocate and therefore avoid unnecessary medical interventions (Kjerulff et al., 1993).

Although African American women tend to have the attitude that menopause is a natural midlife event, with 97% saying a woman should see her doctor at menopause they are also keenly aware of its medical significance. Concern about what to expect during menopause reflects their beliefs that menopause is unpleasant and foreboding. They see few benefits to menopause apart from the cessation of menses and the end of fertility, a view that is also held by Caucasian

women (Mansfield & Voda, 1993). These are not surprising attitudes in a U.S. culture that attaches so little value to the aging process.

Another observation that must not be overlooked in this discussion of menopausal symptomatology is the relatively low reporting of symptoms among this sample of African American women, a finding consistent with findings among nonclinical populations of midlife Caucasian women (Kaufert & Syrotuik, 1981). Although some African American women may experience severe symptomatology that is disruptive to daily living, the current results suggest that the majority experience symptoms occurring on average in the occasional range.

Attitudinal patterns identified by both the MAS and ATM were similar to previous findings by both Neugarten et al. (1963) and Theisen et al. (1995) for samples of Caucasian women. According to both sets of authors, postmenopausal women demonstrate the most positive attitudes toward menopause. The current findings are consistent with other research that suggests women's attitudes toward menopause improve as they experience menopause and move through it (Bowles, 1986; Kaufert & Lock, 1997).

Zero-order correlations also indicated that as a woman ages, her attitudes toward menopause become more positive. The MSL was negatively correlated with income, education, and health, suggesting that women with a higher education, higher income, and better health status have fewer symptoms than women with lower education, lower income levels, and poorer health. However, the MSL was also positively correlated with stress, indicating that women with higher stress levels report more symptoms than women with lower stress levels. Although small, a significant inverse relationship between attitudes toward menopause and symptom reporting was also demonstrated. Taking into account Bowles's (1986) theory that attitudes influence menopausal experience and supporting research, it appears that even a modestly positive attitude toward menopause may benefit midlife African American women as they enter the menopause years.

The stepwise regression analysis identified two variables, age and frequency of symptomatology, as independently helping to explain a small but statistically significant amount of variance in attitudes toward menopause. Of these, age was the most significant, which is consistent with other studies that have found age to be a strong predictor of menopausal attitudes (e.g., Theisen et al., 1995). It has been theorized that young women connect menopause with aging, fear of the unknown, and fear of losing their sexual attractiveness and femininity. This pattern appears to hold true for African American women. Gannon and Ekstrom (1993) suggested that because menopause is not of major concern to young women, their attitudes are most likely determined by cultural stereotypes. As women move through menopause, some "unknowns" and myths are alleviated, affecting their attitudes toward menopause in a positive way (Theisen et al., 1995). According to Jackson (1990), African American women progress through midlife in much the same way as Caucasian women, moving from a reproductive mothering phase to a freer time in which they pursue their own personal development, a process that helps account for age being a strong predictor of attitudes in this sample of women. The results of the correlation and regression analysis in the present study suggest trends that lend support to these theories.

The finding that education, health, and stress account for portions of the variance in menopausal symptoms is also consistent with prior research findings, with stress having the strongest relationship. All of these are factors that are amenable to interventions through counseling and health care.

Implications

The results of this study have several implications for clinical practice, as well as for counselor education and training. Foremost is the need for counselors to understand that, as African American women age, they are faced with the universal experience of menopause and all of the complexities that are associated with it. The picture of midlife African American women that emerged from this study supports a multicultural perspective that fosters the view that there are both commonalities as well as unique differences within ethnic/racial groups. Among each menopausal status group, there were variations in how individual women reported their attitudes about menopause and their symptomatology. Although most women reported an overall positive attitude toward menopause and reported occasional symptomatology, counselors need to keep in mind that individual experiences may vary greatly from the norms. Menopause is multidimensional; influenced by biological, psychological, and sociocultural factors; and requires responses that are equally multidimensional.

The results of this study suggest that African American women can expect that as they enter the perimenopause years, menopausal symptoms will increase. When faced with female midlife clients exhibiting symptoms of anxiety or depression, counselors who are aware of the changes associated with perimenopause may ask about the presence of menopausal symptomatology. The results of multiple studies with Caucasian women suggest that if there is an increase in depression during perimenopause, it appears to subside as women adjust to the changes of this menopausal stage (Matthews, 1992). Women who are experiencing distressing symptoms can be reminded that menopause is a time-limited transition. Discussing normal parameters of the menopausal experience, exploring possible treatments that address estrogen depletion, and suggesting a medical consultation are interventions that can help reduce fear and return some sense of control to perimenopausal women.

The changes of perimenopause may cause women to consider for the first time what it means to grow older in a society that supports ageism (Theisen et al., 1995). Analysis of

specific attitudes held by African American women indicates that negative stereotypes of menopause and menopausal women are present in this ethnic/racial group. For African American women who have had to cope with racism and sexism, menopause may represent one more sociocultural hurdle that threatens their well-being. Counselors need to be sensitive to what aging means to the African American woman and how menopause status affects these perceptions. As more African American menopause research and literature are available, myths can be dispelled by ethnically specific and factual information. Fear of the unknown can be replaced by accurate information, and negative stereotypes can be displaced by healthy role models.

The results of this study support the findings of Neugarten et al. (1963) and other researchers (e.g., Bowles, 1986; Gannon & Ekstrom, 1993) who said that as women age and move through menopause, their attitudes grow more positive. Yet, postmenopausal women indicated they found it more difficult than any other menopause status group to talk to their doctors about menopause. Counselors need to keep in mind that these findings may be due to cohort effects, in that older African American women may not be as open about personal health issues as younger women.

Knowing what to expect in menopause is a strong need of midlife women. Groups designed for this population can provide a supportive environment in which women can identify how their menopausal experiences are both alike and uniquely different from those of other women. Most African American women in this study perceived menopause to be a midlife transition that was unpleasant and somewhat threatening, but it is followed by a postmenopausal recovery characterized by expanded identities and happier experiences. Counselors can encourage women to tell their stories (Lippert, 1997), to talk about their fears, and to share their successes. Women can be reminded that menopause comprises more than isolated physical and mental changes; rather, it is a complex phenomenon that affects the totality of one's personhood and being. Groups provide an opportunity to experience the losses and gains that midlife brings, to adjust and expand personal identities, with the support and love of other women. Valuable personal experiences can be shared, and personal plans for coping with the menopausal experience can be constructed.

Finally, counselors can advocate for their African American menopausal clients by networking with other health care professionals through initiatives such as community coalitions whose agendas support both psychological and medical health care needs. Counselors need to be aware that as many as one third of African American families are poor (U.S. Department of Health and Human Services, 1986), and, as Perlmutter and Bart (1982) warned, many poor women are so overwhelmed by the strains and stresses of life that they have little time or thought for themselves. Psychological and medical health options for such women may include involvement in educational programs, focus groups, and health care through such networks as churches and community organizations. Counselors can encourage women to be self-advocates, by arming them with knowledge about the biological, psychological, and sociocultural aspects of the menopausal experience and by providing information on political and social resources in their community.

The findings of this study are limited by the nature of the convenience sample, including geographic factors and other variables that limit generalizability to the larger population of African American women. Replication of this study among women of lower socioeconomic status is needed to establish norms that are more representative of all midlife African American women. A larger community-based longitudinal study would provide a foundation for more powerful results with better generalizability of research findings. Exclusion of surgically menopausal women and women who are taking hormone replacement therapy would eliminate potentially confounding variables. Future studies that focus on attitudes toward menopause of African American women need to increase the age range to include both younger and older women than were included in this study. Raising the upper age limit to 60 would increase the number of women who are in various stages of postmenopause.

There is also a need for research that focuses on identifying factors that influence attitudes. Instruments that measure each of the possible influencing factors need to be powerful enough to provide good variability. This may require more lengthy measurements than those used in this study and may necessitate a more narrow focus in order to keep the length of the data collection process manageable. In order for African American menopause research to avoid overmedicalizing the phenomenon, it is imperative that researchers take a multifaceted approach, considering the mutual influences of biology, culture, and psychology on the menopausal experience of these women.

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